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Editor's Pick

Spotlight on... training

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Introduction

Training in obstetrics and gynaecology has evolved significantly over the last two decades, offering thrilling opportunities to progress women's health and, at the same time, presenting various challenges to both trainees and trainers. In this Spotlight, we highlight the changes in training reflected in past issues of *The Obstetrician and Gynaecologist (TOG)* from 2001 until now, initially with the implementation of the Modernising Medical Careers (MMC) training scheme, to the introduction of new subspecialty training, and finally, the focus on team learning and non-technical skills. We now recognise the importance of human factors, self-reflection, and learning from Serious Incidents Requiring Investigation (SIRI) as an integral part of the development of the obstetrician and gynaecologist. We explore the issues of alternative training

opportunities allowing doctors to pursue the Certificate of Eligibility for Specialist Registration (CESR) accreditation as an alternative to Certificate of Completion of Training (CCT). In this Spotlight, we also confront the high attrition ([Br J Hosp Med 2017;78\(6\):334–8](#)) and undermining rates reported by trainees, as well as the increasing physician burnout in our speciality.

Practical training in obstetrics and gynaecology

Jane McDougall ([TOG 2003;5:221–5](#)) wrote a comprehensive piece on the European Working Time Directive (EWTD) and MMC. The reduction in working hours and length of training necessitated a more structured and focused style of training. Competency-based summative assessment of practical skills was introduced, supported by evidence from formative and summative workplace-based assessments such as the objective structured assessment of technical skills (OSAT)s. Virtual and distance learning were promoted by the inauguration of the RCOG Education Centre in 2001 and the launch of the StratOG distance learning programme. James, Mears and Draycott ([TOG 2003;5:107–11](#)) acknowledged the need to learn non-clinical skills such as presentation and teaching skills, research, audit, administrative ability and an understanding of the National Health Service in order to function as a competent and safe consultant obstetrician and gynaecologist. The six key competencies described by Bisson, Hyde and Mears ([TOG 2006;8:107–12](#)) still form the basis of the current summative assessments in our speciality (i.e. caesarean section, operative vaginal delivery, perineal repair, manual removal of placenta and surgical management of miscarriage). Simultaneously, benchmarking trainers' knowledge and teaching skills together with the effective and sustainable Training the Trainers courses and curriculum were emphasised by Wood and O'Donnell ([TOG 2001;3:213–7](#)) and Gupta et al. ([TOG 2012;14:39–44](#)).

Team training in Obstetrics and Gynaecology

Fraser, Symonds and Cullen ([TOG 2005;7:271–5](#)) expounded on the concept of shared inter-disciplinary team training and described the example of a pilot initiative in the East Midlands, Nottinghamshire and Derbyshire. Multi-professional training encouraged inter-disciplinary respect and development of a shared mental model when approaching clinical problems. Related to this, Jackson and her colleagues ([TOG 2013;15:269–74](#)), stressed the importance of developing human factors (or non-technical skills) such as communication, team-working and interpersonal skills to complement technical abilities in order to optimise patient care. An understanding of human factors is mandated as a key requirement of the General Medical Council's Generic Professional Capabilities (see <https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework>), and the Non-Technical Skills for Surgeons (NOTSS) tool ([Qual Saf Health Care 2009;18:104–8](#)) developed by the University of Aberdeen and the Royal College of Surgeons of Edinburgh) has now been incorporated as part of the new Royal College of Obstetricians and Gynaecologists (RCOG) training curriculum.

Foundation, academic and subspecialty training

Supplementary to the generic run-through training in obstetrics and gynaecology, three groups of authors discussed foundation ([TOG 2011;13:49–53](#)), academic ([TOG 2010;12:111–8](#)) and urogynaecology subspecialty ([TOG 2008;10:263–6](#)) training. Professor Rymer and co-authors ([TOG 2011;13:49–53](#)) explained the two-year integrated foundation programme, which incorporates the electronic portfolio and competency-based assessments aiming to develop early transferable skills. Anna David and colleagues ([TOG 2010;12:111–8](#)) discussed the integrated academic training pathways and the vast opportunities for trainees to engage in women's health research along their clinical training, and three leading urogynaecologists ([TOG 2008;10:263–6](#)) shared their thoughts on the two- to three-year, seven module urogynaecology subspecialty training programme.

Non-UK trainees

Habbu et al. ([TOG 2004;6:178–81](#)) paid tribute to the historic contribution of overseas trainees to our speciality, exploring their challenges, expectations and hopes. At the time of writing this Spotlight, with Brexit looming and the potential restriction on European staff exchanges, it was interesting to revisit Kevin Jones' article ([TOG 2005;7:126–8](#)) on the European model of consultant delivered gynaecological service, where there was a preponderance of accredited specialists compared with trainees.

Certificate of Eligibility for Specialist Registration pathway

John Eddy – past Chairperson of the RCOG Equivalence Advisory Committee – and his team penned the excellent article on a path through the equivalence minefield ([TOG 2008;10:257–62](#)), which enabled us to understand the process of applying for entry to the General Medical Council (GMC) Specialist Register using the equivalence pathway, also known as Article 14 of the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003. The authors clarified the requirements and offered useful advice on how best to demonstrate evidence of equivalent competence to a CCT holder.

Supporting trainees in difficulty and Serious Incidents Requiring Investigation

Sowden and Hinshaw ([TOG 2011;13:239–46](#)) wrote on the complexity of recognising trainees in difficulty (including those with addiction problems), how to manage their issues and how to set SMART objectives at their Annual Review of Competence Progression (ARCP) meetings. A transatlantic viewpoint was shared by two senior residency directors from the USA ([TOG 2011;13:247–51](#)), highlighting the challenges of residency 'remediation' and the need for accurate documentation in order to meet legal

requirements. They identified three areas of deficiencies which may lead to remediation, these being poor knowledge, substandard technical skills and deficiencies in professionalism.

Macdonald and colleagues ([TOG 2014;16:109–14](#)) reminded us that at some point in their training, trainees are likely to encounter a SIRC (previously Serious Untoward Incident), which can affect their progress and performance. Both trainers and trainees are more cognisant of the processes raised in the event of such incidents and the need to document this on Form R prior to the ARCP. Likewise, it is now standard practice for trainees to engage in a team debriefing after a critical incident as this can provide invaluable support ([TOG 2008;10:251-6](#)) and avoid second victim syndrome.

Bullying behaviour and burnout

Traditionally, obstetrics and gynaecology maintained a reputation as a highly litigious and work-intense speciality with an unacceptably high rate of reported undermining and bullying. The article by Geeta Kumar and her co-authors ([TOG 2012;14:130–5](#)) helped us understand the definition of bullying (as opposed to constructive criticism) as well as its consequences and provided us with resources to deal with this perennial GMC chestnut.

The term ‘burnout’ is often used indiscriminately nowadays and Cresswell and co-authors’ commentary ([TOG 2019;21:7–9](#)) brought us back to the original description of a syndrome of ‘emotional exhaustion, reduced personal accomplishment and depersonalization’. They remind us how the condition can affect physician performance, patient safety and trainee attrition and elaborated on strategies which help reduce burnout. Sadly, pooled data from various studies indicated that overall improvement following interventions was modest (a decrease of 10%), thus emphasising that burnout is best avoided than treated.

Last words

Obstetrics and gynaecology continues to be one of the most rewarding medical specialities with great opportunities to positively impact women and their families. Facing the ever-evolving challenges and the growing pool of knowledge, we must actively invest in educating and training our trainees supporting their development as top-class health professionals contributing to women's healthcare.

An online collection of all articles relating to Training is available at onlinetog.org.